GoKinD
Genetics of Kidneys in Diabetes Study

Current Medication Form

This form should be completed as part of the Medical History and Physical Examination on Proband/Relatives.

A. IDENTIFYING INFORMATION

1. Clinic Number: __ __ __
2. Family ID Number: __ __ __ __ __ __ __ __
3. Proband/Relative Code: __ __
4. Proband/Relative's Initials: __ __ __ (F M L)
5. Date Form Completed: __ __/__ __/__ __ (Month Day Year)
6. Certification Number: __ __ __.__ __

B. CURRENT MEDICATION

1. Does the proband/relative use aspirin? No (1) Yes (2)

   If No, go to B.2.

   a) Aspirin

      1. During the last month has the proband/relative taken any aspirin? (1) (2)

   If No, go to B.2. If Yes, answer the following:

      1. How many days, during the last month, has the proband/relative taken aspirin? __ __ days
      2. How many tablets of aspirin has the proband/relative taken aspirin during the last month? __ __ __ tablets

   b) Does the proband/relative use prescription or non-prescription medications? No (1) Yes (2)

   If No, stop here and save and exit the form

2. Does the proband/relative use vitamin and/or mineral supplements on a regular basis? No (1) Yes (2)

   If No, go to B.3. If Yes, answer the following:

   a) Does the proband/relative use Vitamin E regularly? No (1) Yes (2)

      1. If YES, specify: ____________________

   b) Does the proband/relative use any other vitamin and/or mineral supplement besides Vitamin E on a regular basis? No (1) Yes (2)

      1. If YES, specify: ____________________

   If No, stop here and save and exit the form

	No	Yes
3. Has the proband/relative taken lipid lowering medications? (see attached list of medications in section – lipid lowering)	(1)	(2)

If No, go to B.4.

a) If YES, specify name and dose:______________________________

____

	No	Yes
b) Does the proband/relative use other prescription or non-prescription medications?	(1)	(2)

If No, stop here and save and exit the form

	No	Yes
4. Has the proband/relative taken ACE inhibitors?(see attached list of medications in section - ACE inhibitors)	(1)	(2)

If No, go to B.5.

a) If YES, specify name and dose: ______________________________

____

	No	Yes
b) Does the proband/relative use other prescription or non-prescription medications?	(1)	(2)

If No, stop here and save and exit the form

	No	Yes
5. Has the proband/relative taken antihypertensives regularly?	(1)	(2)

If No, go to B.6. If Yes, answer the following.

	No	Yes
a) Diuretics	(1)	(2)

If Yes, answer each:

1. Hydrochlorothiazide	(1)	(2)
2. Other thiazide diuretic	(1)	(2)

a) If YES, specify: ______________________________

____

3. Furosemide	(1)	(2)
4. Other loop diuretic	(1)	(2)

a) If YES, specify: ______________________________

____

5. Metolazone	(1)	(2)
b) Beta blockers	(1)	(2)

1. If YES, specify: ____

____

	No	Yes
c) Labetalol	(1)	(2)
d) Prazosin-like agents (Minipress, Minizide, Hytrin)	(1)	(2)
e) Hydralazine (Apresoline, Reserpine, Serpasil)	(1)	(2)
f) Guanabenz (Wytensin)	(1)	(2)
g) Clonidine (Catapress)	(1)	(2)
h) Methyldopa	(1)	(2)
i) Minoxidil	(1)	(2)
j) Calcium channel blockers	(1)	(2)
k) Other	(1)	(2)

1. If YES, specify: ____

____

	No	Yes
l) Does the proband/relative use other prescription or non-prescription medications?	(1)	(2)

If No, stop here and save and exit the form

	A. Right Eye		B. Left Eye	
	No	Yes	No	Yes
6. Has the proband/relative used ocular medications which require a prescription?	(1)	(2)	(1)	(2)

If No, go to 7. If Yes, answer the following:

	A. Right Eye No	A. Right Eye Yes	B. Left Eye No	B. Left Eye Yes
a) Steroid drops	(1)	(2)	(1)	(2)
b) Glaucoma drops	(1)	(2)	(1)	(2)
c) Mydriatics	(1)	(2)	(1)	(2)
d) Other (specify below)	(1)	(2)	(1)	(2)

1) right eye: ______________________________

2) left eye : ______________________________

e) Does the proband/relative use other prescription or non-prescription medications? No (1) Yes (2)

If No, stop here and save and exit the form

7. Does the proband/relative take oral medication(s) to control their diabetes? (mark all)

	No	Yes
a) Alpha Glucodiase Inhibitors	(1)	(2)
b) Biquanides	(1)	(2)
c) Insulin Secretagogues	(1)	(2)
d) Thiazolidinediones	(1)	(2)
e) Sulfonylureas	(1)	(2)
f) Meglitinides	(1)	(2)
g) Other	(1)	(2)

1. If YES, specify name and dose: ______________________________

____

8. Has the proband/relative taken any other medication(s) not previously specified? No (1) Yes (2)

a) If YES, specify name and dose: ______________________________

____

Signature of person who completed this form:

____